

PRINTED: 12/29/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2016
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, FT SANDERS		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 HIGHLAND AVE KNOXVILLE, TN 37916			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey conducted on 12/12/16 through 12/14/16, at NHC Healthcare, Ft. Sanders, no health deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000	No response needed		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

5599

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If continuation sheet 1 of 1